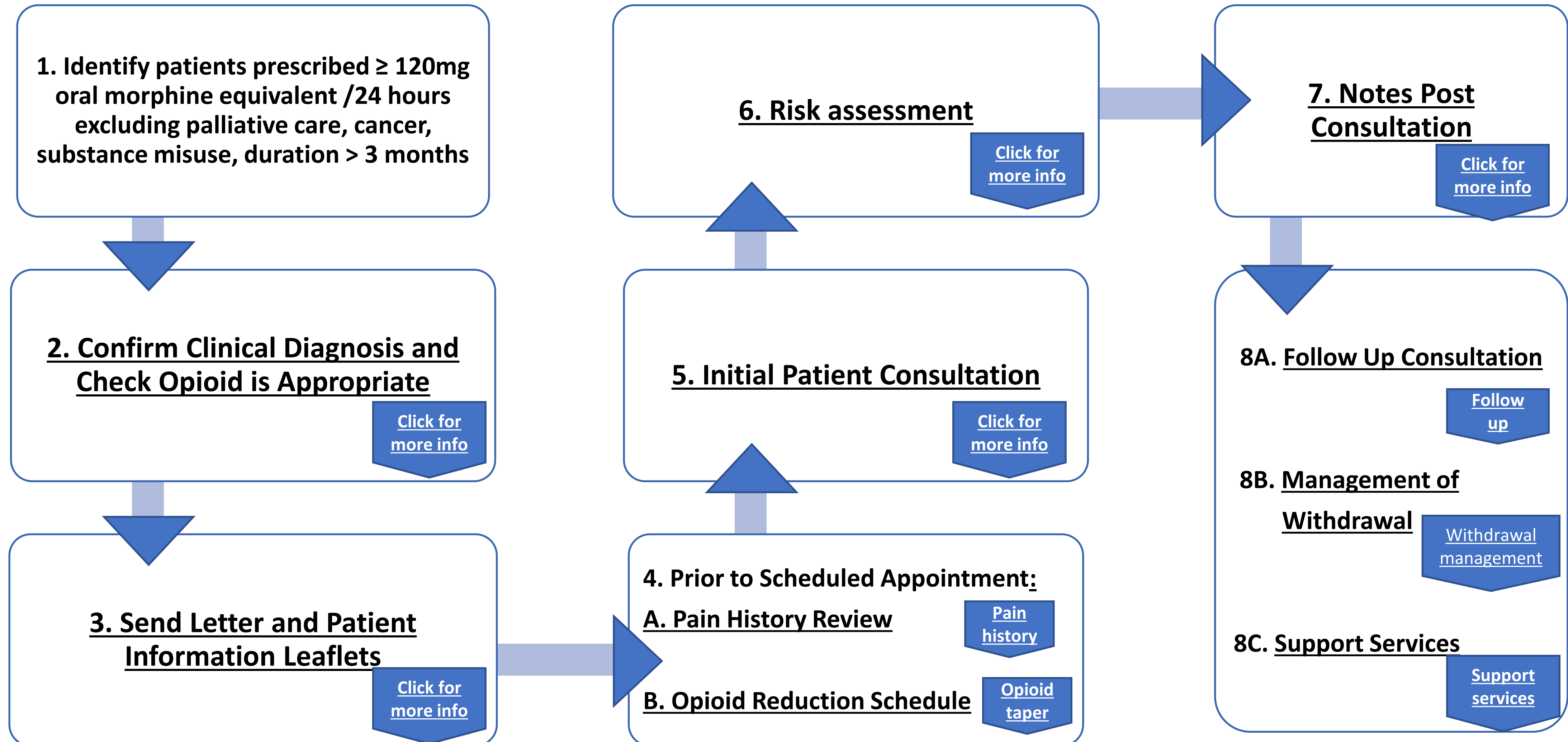
Managed Opioid Reduction Tool step wise approach

(Non-Cancer Pain > 3 months duration in adults in primary care)

The aim of the opioid reduction tool is to taper prescribing and reduce opioid risk for patients. If patient is still complaining of pain despite opioids ≥ 120mg morphine equivalent, then opioids are not working and should be weaned down and stopped.



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Confirm Clinical Diagnosis

Are opioids clearly indicated?

Do the GP notes show:

- Confirmed pain diagnosis
- Co-morbidity
- Mental health status
- Current substance misuse or drug seeking behaviour indicating opioid dependence syndrome (refer to CGL/Spectrum)

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Sample Letter and Patient Information Leaflets

- View the example letter (approved by the Hertfordshire Patient Reader Group) to invite patients for consultation

Patient Information Sources

Leaflets:

- Driving and Pain information leaflet, Faculty of Pain Medicine
- Taking Opioids for Pain leaflet, Faculty of Pain Medicine
- Ten Footsteps to Living Well with Pain
- Medicines and their risk of addiction leaflet, MHRA
- Flippin' Pain on-line resources
- The Pain Toolkit – online resource with guidance on managing pain. NB some content requires payment

World Health Organisation Animated Videos:

- Depression: https://www.youtube.com/watch?v=XiCrniLQGYc
- Stress: https://www.youtube.com/watch?v=I6402QJp52M

Apps available on Google Play and the Apple Store:

- Mindfulness : https://www.headspace.com/headspace-meditation-app
- Active Walking: https://www.nhs.uk/oneyou/active10/home#xfEeV0FM3W4Xo5gM.97

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Pain History Review

Be aware that anxiety and depression often co-exist with chronic pain. Pre-existing anxiety and depression are likely to worsen during an opioid reduction. Addressing these will likely be an important part of ongoing treatment and a referral to IAPT (Improving access to Psychological Therapies) should be considered if the individual is not already receiving treatment for these common mental health conditions.

- 120mg oral morphine equivalent/24 hours is the dose above which harm outweighs benefit. **THIS IS NOT A TARGET DOSE**. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued even if no other treatment is available.
- View Faculty of Pain Medicine dose equivalence chart.

Review process:

- ❑ Assess risk of dependence
- ❑ Consider appropriate non-medication treatments e.g. IAPT referral, Musculoskeletal Service (MSK) pain management workshops
- ❑ Rate of withdrawal should be individualised according to the dose, and duration of treatment. Patient factors such as personality, lifestyle, previous experience and specific vulnerabilities should also be taken into account.

Review current opioid therapy checklist:

- ❑ Has opioid therapy produced and maintained a measurable improvement in the patient's pain and/or functional capacity, reduction in pain intensity, or specific functional improvement/ improvement in sleep?
- ❑ Is the patient substantially free from adverse effects of opioid therapy including harm associated with long term use?
- ❑ Is there continued absence of inappropriate dose escalation, aberrant behaviours, misuse or abuse of opioids?
- ❑ Has a reduction in opioid therapy been trialled?

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Opioid Reduction Schedule

Prepare medication reduction schedule*:

- ❑ Recommend 10% reduction every one to two weeks tailored to needs of patient.
- ❑ Start with reducing short-acting medicines followed by long-acting medicine
- ❑ Start from the most relevant point of the schedule depending on the patient's current dose.

Oxford University Hospital templates for opioid reduction**

Other prescription drugs of dependence:

- ❑ Do not increase or add -in alternative medicines such as pregabalin, gabapentin, or dihydrocodeine.

Pregabalin Drug Safety Update: Pregabalin: reports of severe respiratory depression

Gabapentin: Drug Safety Update: Gabapentin: risk of severe respiratory depression

***Where possible dose reduction should be undertaken without switching opioids.**

- Switching opioid should only be undertaken by a healthcare practitioner with adequate competence and sufficient experience.
- If conversion unavoidable, consider the half-life of long-acting drugs. In most cases, when switching between different opioids, the calculated dose equivalent must be reduced to ensure safety. The starting point for dose reduction from the calculated equianalgesic dose is 25-50%.

Further guidance on dose equivalence: https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids

**Shared with permission from Oxford University Hospital pain team

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Patient Consultation

- Medications should be a small part of the pain management plan and should be used in conjunction with non-pharmacological interventions such as advice regarding activity and physiotherapy. It must be explained that pain may be resistant to medication and complete relief of symptoms is not a goal of therapy.
- Ask whether the patient would like support from a family member, carer, advocate or other person close to them at their appointments.
- Discuss referral options if appropriate (including referral to social prescribers, wellbeing services or specialist MSK team for non-pharmacological pain management if MSK pain is primary diagnosis, see Support Services).
- Agree outcomes of opioid tapering with the patient, patient collaboration and engagement is key to success. Throughout the process it is important to provide advice on pain management, expectations of treatment and possibility of anxiety, depression and hyperalgesia on withdrawal.
- Provide patient-tailored medication reduction schedule.
- Reassure patient about follow up, monitoring and support during the tapering process with fortnightly or weekly telephone calls with the same healthcare professional (where possible). They need to be ready for the lower dose when they collect their next prescription. Reassure patients that if they are experiencing any difficulty with the withdrawal schedule, they can contact the surgery for advice.
- Ensure that patient is aware that responsibility for prescribing will lie with the clinician responsible for the dose reduction plan.
- **A copy of the dose reducing schedule should be given to the patient and the patient's pharmacy. A copy should also be kept in the patient's notes.**

Opioid Management Plan: Treatment Agreement

- Consider use of patient treatment agreement (optional)

Reviewed by the Hertfordshire patient reader panel. This treatment agreement is optional and may be used where the clinician feels appropriate.

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Risk Assessment

- Consider use of **opioid risk tool** to assess risk for opioid abuse.
- This tool should be administered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management. A score of 2 or lower indicates low risk for future opioid use disorder; a score of ≥3 indicates high risk for opioid use disorder.
- If the patient is considered high risk based on the assessment tool on this page, then a clinical review of the case by an experienced or specialist GP or referral to a secondary care specialist is highly recommended. Follow GMC advice and do not prescribe if not in the person's best interests.

Mark each box that applies	Yes	No
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring totals		

Cheatle M, Compton P, Dhingra L, Wasser T, O'Brien. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Non-Malignant Pain. *Journal of Pain*. 20 (7): 842-851, 2019.

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Notes post consultation

- ❑ Document clearly the plan that has been agreed with the patient
- ❑ Ensure that the patient is not inadvertently prescribed opioids by colleagues. This requires good communication within the practice, with locum services and if necessary out of hours [send email to huc.feedback@nhs.net], community pharmacies and emergency services.
- ❑ Add SNOMED code to clinical system (dose reducing regimen)

Drug dose reducing regime (procedure)

Concept ID: 304771000000101

Description ID: 541641000000111

- ❑ Advise other services on how the patient should be managed in the event that they request additional opioid treatment to manage pain, i.e. as part of weaning management plan.

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Follow Up Consultation

- At each stage enquire about general progress and withdrawal symptoms. A useful tool to support this is the Patients’ Global Impression of Change scale
- If patients experience difficulties with a dose reduction, encourage them to persevere and suggest delaying the next step down by one week and discuss importance of using non-drug related pain management strategies. Do not revert to a higher dosage unless withdrawal symptoms are severe and intractable, avoid adding PRN opioids or other adjuvant agents see below.
- Frequency of review depends on rate of taper and degree of support required e.g. monthly if 10% drop every 1 to 2 weeks
- Ask about reduction in side effects, improvements in alertness, daily living, mobility and emotional well-being as well as withdrawal symptoms and pain
- See local resources for persistent pain produced by West Essex and ICB pathway resources
- Document clearly all consultations in patient notes.

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Management of Withdrawal Symptoms

- [ ] **Assess withdrawal symptoms:**

[Subjective Opiate Withdrawal Scale: SOWS]

[Clinical Opiate Withdrawal Scale: COWS]

- [ ] **If withdrawal symptoms are an issue:**
  - Consider holding the tapering dose and whether the tapering rate needs to be slowed down.
  - Do not treat withdrawal symptoms with another medicine that is associated with dependence or withdrawal symptoms.
  - In a small number of cases you may need to revert back to the previous dose.
- [ ] **Consider the following if symptoms are severe:**
  - Anti-emetic
  - Smooth muscle relaxant
  - Diarrhoea: Loperamide
  - Tremor: Beta-blocker
  - Bone or joint aching: Paracetamol
  - Anxiety or irritability: Mindfulness

Advise patient: although withdrawal symptoms may occur during the tapering process and are unpleasant, they are rarely medically serious. Whilst most withdrawal symptoms settle within a few weeks some may persist for up to 6 months after discontinuation of opioids.

Reference: Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults: NICE guideline [NG215] Published: 20 April 2022. https://www.nice.org.uk/guidance/ng215

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Support Services

Social prescribers

In Primary Care Networks OR HertsHelp

MSK* Services

Hertfordshire Community Trust (HCT) (ENH), Connect (HV)

Essex Partnership University Trust (EPUT) (West Essex)

*(Musculoskeletal Persistent Pain Management Programme)

Wellbeing services:

Hertfordshire patients - Wellbeing Service talking therapies and practical support for mental health problems.

West Essex patients - Essex Wellbeing Service

IAPT Hertfordshire:

IAPT (Improving access to Psychological Therapies) in HPFT including CBT and one to one support:

- Information about the service, access to resources, self help materials and webinars
- Self referral;
- Professionals page and submit a professionals referral.

IAPT West Essex patients:

Vita Health Group

Hertfordshire Drugs & Alcohol service:

CGL/Spectrum Hertfordshire Drugs and Alcohol Service